Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL IMAGING OF PLANO
2109 WEST PARKER ROAD SUITE 720
PLANO TEXAS 75023

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-05-4903-01

MFDR Date Received
February 23, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Procedure is compensable for payment."

Amount in Dispute: $1,591.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has reviewed and has sent for processing."

Response Submitted by: Broadspire on behalf of NATLGCO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 27, 2004	A4215, 99499, 62290, A4646, 72132 and 72295	$1,591.29	$1,213.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute filed on or after January 1, 2002.
2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services provided on or after September 1, 2002.
3. Division rule at 28 TAC §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 23, 2004
   - F 866-003 – This procedure code is not eligible for ASC reimbursement per the fee schedule. $0.00

   Explanation of benefits dated January 31, 2005
   - F 866-003 – This procedure code is not eligible for ASC reimbursement per the fee schedule. $0.00
   - 900-999 – Based on further review, no additional payment is warranted
   - F – Fee Guideline MAR reduction $0.00

Issues

1. Did the requestor bill for bundled HCPC codes for date of service October 27, 2004.
2. Did the requestor submit documentation to support the billing of CPT codes 62290, 72132, and 72295?
3. Did the requestor submit documentation to support fair and reasonable reimbursement for HCPC codes 99499, A4215 and A4646?
4. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine if edit conflicts exists for date of service October 27, 2004. Review of the CCI edits finds:
   - No CCI edit conflicts were identified on the disputed HCPC codes A4215, 99499, 62290, A4646, 72132 and 72295.
2. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Review of the submitted documentation finds:
   - The CPT code description for procedure code 62290 is Injection procedure for discography, each level; lumbar.
   - The CPT code description for procedure code 72132 is Computed tomography, lumbar spine; with contrast material
   - The CPT code description for procedure code 72295 is Discography, lumbar, radiological supervision and interpretation.
   - Review of the documentation submitted by the requestor indicates that the requestor billed and rendered a Lumbar Discogram with Post Discogram CT Scan.
   - The requestor is therefore entitled to reimbursement for CPT codes 62290, 72132 and 72295.

   Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used." Review of the submitted documentation finds:

   - The requestor is disputing one unit of CPT code 62290. The requestor billed with place of service 11, which identifies that the services were rendered in an office. The Medicare non facility rate is $345.15 x 125% = $431.43. The requestor is entitled to $431.43.
   - The requestor is disputing one unit of CPT code 72132. The requestor billed with place of service 11, which identifies that the services were rendered in an office. The Medicare non facility rate is $ 309.18 x 125% = $386.47. The requestor is entitled to $386.47.
   - The requestor is disputing one unit of CPT code 72295. The requestor billed with place of service 11, which identifies that the services were rendered in an office. The Medicare non facility rate is $316.37 x 125% = $395.46. The requestor is entitled to $395.46.
   - The total recommended amount is $1,213.36.

3. Per 28 Texas Administrative Code §134.202 (c)(2)(A, B and C) "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule. (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection. Review of the submitted documentation finds:

   - Review of the DMEPOS fee schedule (cgsmedicare.com) did not contain a fee schedule amount for HCPC codes A4215 and A4646.
   - Review of the Texas Medicaid Fee Schedule did not contain a fee schedule amount for HCPC codes A4215 and A4646.
   - Review of the Medicare Fee Schedule, did not contain a fee schedule amount for CPT code 99499.
   - HCPC codes 99499, A4215 and A4646 are therefore subject to the provisions of 28 Texas Administrative Code §134.1.

   Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

   Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor billed HCPC codes 99499, A4215 and A4646 on October 27, 2004.
   - The HCPC code indicated above does not have a Medicare or Texas Medicaid assigned value.
   - Division rule at 28 TAC §134.1, effective May 16, 2002 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges HCPC codes 99499, A4215 and A4646.
   - Documentation of the comparison of charges to other carriers was not presented for review.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Payment cannot be recommended HCPC codes 99499, A4215 and A4646.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,213.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,213.36 plus applicable accrued interest per 28 Texas Administrative Code §134.803 for dates of service prior to 5/2/06, due within 30 days of receipt of this Order.

Authorized Signature

		March 7, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.